

Report of the
Special Committee on Medicaid Reform
to the
2006 Kansas Legislature

CHAIRPERSON: Senator Derek Schmidt

VICE-CHAIRPERSON: Representative Melvin Neufeld

RANKING MINORITY MEMBER: Representative Jerry Henry

OTHER MEMBERS: Senators Jay Emler, Anthony Hensley, Tim Huelskamp, Laura Kelly, and Dwayne Umbarger; and Representatives Bob Bethell, Mike Kiegerl, Nancy Kirk, and Don Myers

STUDY TOPIC

Medicaid Review

Special Committee on Medicaid Reform

MEDICAID REVIEW

CONCLUSIONS AND RECOMMENDATIONS

Client Responsibility

- The Committee recommends demonstration projects in one rural and one urban area that reward Medicaid clients for making healthy lifestyle changes and consideration of other demonstration projects that create incentives to be more prudent health care consumers.
- The Committee recommends specified state agencies work to coordinate efforts to insure that persons being discharged from a hospital or being evaluated for a nursing facility placement are informed of the array of services in the community as alternatives to a nursing facility.
- The Committee recommends the Kansas Health Policy Authority review and evaluate Cash and Counseling and Independence Plus demonstrations in other states that provide Medicaid clients more personal responsibility in choosing services and providers and report to the Legislature on programs that could be successfully implemented in Kansas.

Cost Containment

- The Committee recommends a Committee bill that creates new law relating to payroll agents and family care providers.
- The Committee recommends a Committee bill that would authorize the Attorney General to bring a civil action for false claims filed with any agency of the state.
- The Committee recommends 2005 House Bill 2445, which would amend present law to add Medicaid fraud to the list of crimes for which seizure and forfeiture is allowed, be rereferred to the House Committee on Corrections and Juvenile Justice and a hearing be held. The Committee supports passage of the bill.
- The Committee recommends the 2006 Legislature review the need for a more complete identity verification for persons accessing the Medicaid program and consider a procedure similar to the motor vehicle operators' source verification process developed by the Department of Revenue should be implemented for Medicaid applicants.
- The Committee has drafted and introduced a bill that would create an Office of Inspector General in the Kansas Health Policy Authority and recommends the bill be enacted by the 2006 Legislature.
- The Special Committee on Medicaid Reform recommends the Division of Health Policy and Finance move forward in implementing Medicaid presumptive eligibility determination for new applicants for Social Security Disability Insurance and Supplemental Security Income.

- The Committee encourages the Division of Health Policy and Finance to establish caps on the value of an automobile and personal effects that are exempt from being counted in meeting the spend-down necessary to qualify for Medicaid.
- The Committee recommends specified state agencies review the cost containment strategies submitted by a Sedgwick County group and report to the 2006 Legislature.

Long-Term Care

- The Committee has introduced a bill that would authorize the creation of adult care home liability insurance pools and recommends the bill be referred to the House Committee on Insurance.
- The Committee recommends the Department on Aging adopt a new nursing facility reimbursement policy that re-bases the compensation paid to facilities annually and that the new base be computed using a rolling average of cost figures for the prior three years.
- The Committee reviewed 2005 House Bill 2538 that concerns a tax on certain nursing facilities which would be returned, along with matching federal funds to increase payments to such facilities and other adult care. The Committee recommends the Health Policy Authority and the Department on Aging consult with the Centers for Medicare and Medicaid Services about the possibility of a provider tax and determine whether community based services would have to be included.
- The Committee recommends a Committee bill creating enabling legislation that would authorize implementation of a partnership program that allows persons who utilize long-term care insurance to pay for the cost of their care to protect some of their assets should they exhaust their insurance and become eligible for Medicaid. Implementation is dependent on a change in federal policy. The Committee further recommends members of the legislative and executive branches work with members of Congress and national organizations to encourage the Congress to give the states freedom to develop partnership programs.
- The Committee supports changes in federal policy to increase the “look back” period that applies to an unlawful transfer of assets to become eligible for Medicaid and moving the start date for calculation of the penalty period for such transfers and recommends working through the Kansas Congressional delegation to bring about support for federal legislation making changes in the policy regarding transfer of assets. The Committee also recommends the 2006 Legislature adopt legislation directing the state Medicaid agency to make changes in state policy in regard to transfer of assets as soon as federal law permits.

System Changes

- The Committee recommends the Division of Health Policy and Finance immediately require every pharmacy claim form to include the prescriber’s Drug Enforcement Administration identification number.

- The Committee recommends, with the approval of the Legislative Coordinating Council, a letter be sent to the Kansas Congressional delegation urging them to support Medicaid reforms that would give the states more flexibility in determining the rates paid for prescription drugs under the Medicaid program.

Proposed Legislation: The Committee recommends five bills.

BACKGROUND

The Special Committee on Medicaid Reform was created by the Legislative Coordinating Council and authorized to meet in the interim prior to the beginning of the 2006 Legislature. Against a background of steadily increasing Medicaid expenditures that have grown from slightly over \$877,000,000 in fiscal year 1997, to an estimated \$2.2 billion in fiscal year 2006, and a projected \$3.3 billion within five years at the current rate of growth,* the Special Committee was charged by the Legislative Coordinating Council with reviewing the state Medicaid program with the goal of determining the efficiency and cost effectiveness of the services delivered, as well as the appropriateness of the populations served. The charge to the Committee requested particular attention be given to changes in Medicaid resulting from implementation of the Medicare Part D pharmacy benefit, *i.e.*, fewer Medicaid beneficiaries receiving pharmacy benefits, “clawback” payments, and increased numbers of dual eligibles (persons eligible for both Medicare and Medicaid) on the state Medicaid rolls; reexamination of the *Report of the President’s Task Force on Medicaid Reform* and review of the cost containment strategies recommended by the Task Force. In addition, the Committee was asked to focus on recommendations for other cost containment strategies, including wellness, prevention, and nutrition programs.

* See Appendix A for a chart showing actual and projected Medicaid expenditures.

COMMITTEE ACTIVITY

The twelve-member Special Committee on Medicaid Reform met six times during the interim—two days in September, one day in October, and a one-day and a two-day meeting in November. The meetings included an intense review of Kansas Medicaid and the complexities of the Medicaid program, receiving and discussing a large amount of data, hearing conferees, and receiving reports on issues the Committee members singled out for additional attention. Minutes and attachments for the meetings are on file in the Office of Legislative Administrative Services.

September

The Special Committee held two one-day meetings in September.

At the initial September meeting the members reviewed the charge to the Committee; participated in an overview of Medicaid and the program transition from the Department of Social and Rehabilitation Services to the Division of Health Policy and Finance in the Department of Administration; received estimates of the costs of serving various Medicaid populations in the current fiscal year and over a subsequent five-year period; reviewed the recommendations for changes in the Medicaid program of the 2003 *President’s Task Force on Medicaid Reform*, the National Conference of State Legislatures *Principles for Medicaid Reform*, the National Governors Association *Short-Run Medicaid Reform*, and the short-term recommendations of the Medicaid Commission appointed by the

Secretary of Health and Human Services to develop recommendations for options to achieve \$10 billion in scorable Medicaid savings over the next five years and recommendations for longer-term changes in the Medicaid program.**

The Committee heard presentations by the Legislative Post Auditor on a series of audit reports on the Medicaid program; the State Medicaid Director; the Director of Health Care Finance and Organization of the Kansas Health Institute; and reviewed written material from AARP Kansas, a contracted case manager with the South Central Kansas Area Agency on Aging, and the Kingman County Council on Aging. Committee members outlined issues seen as a priority for further exploration by the Committee.

The second September meeting was largely devoted to Medicaid fraud and abuse, including a briefing by the Director of Medicaid on the Medicaid Management Information System (MMIS), the types of information the system can produce, and the role of the system in the prevention of provider fraud and abuse. The Director of the Division of Health Policy and Finance presented an overview of Kansas Medicaid, giving special emphasis to the drivers of increases in the Medicaid population and expenditures, the areas in which expenditures are growing at the fastest rate, the “woodworking” effect of waiver programs, marginal savings that could be initiated, and structural changes that are required to make a substantial impact on cost growth. The Legislative Post Auditor reviewed an audit done by Bland and Associates on controlling fraud and abuse in the Medicaid program and the changes made since the audit was presented to the Legislature. The Director of Medicaid discussed the Fraud and Abuse Detection System (FADS) implemented in 2003 and

provided copies of the fraud and abuse regulations for member review. The Director of the Medicaid Fraud Control Unit in the Office of the Attorney General briefed the Committee on federal law and regulations and the role of the Unit and its operation, and provided the Committee with various documents relating to fraud and abuse. The President of Kansas Taxpayers Against Fraud addressed the Committee on the organization’s proposed Kansas False Claims Act. It was noted a member of the House was preparing a bill for introduction that would create a private cause of action for fraud involving the state and its agencies.

October

At the October meeting the Committee reviewed the Medicaid Home and Community Based Services waiver programs, the roles of nursing facilities, nursing facilities for mental health, and intermediate care facilities for the mentally retarded, and long-term care insurance. Conferees included the Secretary of Aging; representatives of the Kansas Association of Homes and Services for the Aging, the Kansas Health Care Association, the Providence Living Center in Topeka, the Applewood Rehabilitation Center in Chanute, the Alliance for Kansans With Developmental Disabilities, the Statewide Independent Living Council of Kansas, the Big Tent Coalition, the Disability Rights Center of Kansas, Kansas Association of Centers for Independent Living, Interhab, Kansas Association of Area Agencies on Aging, Self Advocate Coalition of Kansas, and the Kansas Council on Developmental Disabilities; and a consumer of home and community based services, a civil rights activist, the Commissioner of Insurance, the Director of Policy and Research of the Department of Revenue, and the Director of Community Supports and Services in the Department of Social and Rehabilitation Services. A written communication was received from a consumer advocate.

** The Committee also received a paper outlining the positions of the American Legislative Exchange Council on Medicaid change at a later meeting.

November

There were three days of Committee meetings in November—a one-day meeting early in the month and a two-day meeting later in November.

At the early November meeting the Committee reviewed information on the regular Medicaid program and MediKan; services for the medically underserved; responses to questions about the Medicaid pharmacy program; recommendations from a Sedgwick County group on cost containment strategies; prescription drug pricing; an overview of the role of the Division of Health in the Department of Health and Environment; and follow-up information on issues raised at previous meetings. In addition, the Committee participated in a question and answer session on reforming Medicaid led by a conferee from Cleveland State University, reviewed bill drafts requested at an earlier meeting, and reviewed three bills introduced during the 2005 Session. Conferees included the Director of Medicaid, the Executive Director of the Kansas Association for the Medically Underserved, a representative of Electronic Data Systems (EDS), the Director of Human Services in Sedgwick County, an individual who was brought to Kansas by the Flint Hills Foundation to speak at a meeting on reforming Medicaid, a physician, and the Director of the Division of Health in the Department of Health and Environment.

At the final two-day meeting of the Committee in November, the members developed recommendations, reviewed and approved draft legislation, received responses to questions about estate recovery, and received information about the Pennsylvania Medical Care Availability and Reduction of Error Act. Conferees who presented information to the Committee included the Director of Medicaid; an investigative attorney from the Estate Recovery Unit; Representative Sydney Carlin; two representatives of the

Department on Aging; and the Director of Another Day, a Medicaid billing agency.

The Special Committee on Medicaid Reform heard and considered a number of recommendation for changes in Medicaid, ranging from a far-reaching total restructuring of the program to changes that concern one or more of the services or populations that make up the Medicaid program in Kansas. While the Committee considers many of the proposed changes to merit further consideration and evaluation by the Kansas Health Policy Authority, the members also believe there are some changes that can be initiated more immediately.

MEDICARE PART D AND KANSAS MEDICAID

As requested by the Legislative Coordinating Council in its charge to the Committee, the members received information about the effect on the Kansas Medicaid program of implementation of the new drug benefit under Part D of Medicare. The Medicare Prescription Drug, Improvement, and Modernization Act of 2003, (P.L. 108-173) enacted December 8, 2003, created a new Medicare Part D prescription drug benefit, effective January 2006. The new Medicare Part D plan requires that every Medicare beneficiary have access to prescription drug coverage.

Beginning in January 2006, the drug benefits offered by Part D will be provided by private insurance plans for a monthly premium, estimated at \$35 per month by the Congressional Budget Office. Under the standard benefit, beneficiaries will pay:

- The first \$250 in drug costs as a deductible;
- 25.0 percent of drug costs between \$250 and \$2,250;

- 100.0 percent of drug costs between \$2,250 and \$5,100, often referred to as the “hole in the doughnut;” and
- To a limit of \$3,600 out of pocket.

After reaching the \$5,100 limit for total pharmaceutical expenditures, referred to as the “catastrophic threshold,” beneficiaries must pay the greater of either \$2 for generic or \$5 for brand name drugs, or 5.0 percent coinsurance. Deductibles, benefit limits, and catastrophic thresholds are indexed to rise with the growth in per capita Part D spending. This growth will result in the maximum benefit gap or “doughnut hole” amount increasing from \$2,850 in 2006 to an estimated \$4,984 in 2014.

Low Income Assistance

The Congressional Budget Office estimates that 14.1 million beneficiaries will be eligible for assistance based on low income and limited assets. Those eligible for full Medicaid benefits, approximately 6.3 million beneficiaries, are considered “dual eligibles.” In 2006, these beneficiaries will begin receiving drug benefits from Medicare, rather than Medicaid. Under Medicare Part D, those with incomes below 150.0 percent of the Federal Poverty Level (FPL) – (\$14,355 for an individual in 2005) – will pay reduced drug costs as outlined below:

Medicare Prescription Drug Coverage					
	150%+ FPL	Incomes between 149-135% FPL	Incomes below 135% FPL	Medicaid Eligibles over 100% Poverty (would have a required spend down)	Medicaid Eligibles under 100% Poverty
Premiums	\$32.20/month	Subsidies on a sliding scale	\$0	\$0	\$0
Deductible	\$250	\$50	\$0	\$0	\$0
Co-pay for costs between \$250 and \$2,250	25.0%	15.0%	\$2-\$5 co-pay	\$2-\$5 co-pay	\$1-\$3 co-pay
Co-pay for costs between \$2,250 and \$5,100	100.0%	15.0%	\$2-\$5 co-pay	\$2-\$5 co-pay	\$1-\$3 co-pay
Payment after \$3,600 threshold					
Generics	\$2	\$2-\$5 co-pay	\$0	\$0	\$0
Brand Name Drugs	\$3	\$2-\$5 co-pay	\$0	\$0	\$0
Or coinsurance percentage	5.0%	0.0%	0.0%	0.0%	0.0%
* \$32.20 is the average monthly premium in 2006.					

Availability of Drug Plans

Medicare will contract with private insurance companies to provide the Part D prescription drug benefit. Coverage will be available through two types of private plans:

- Private prescription drug plans that offer drug-only coverage.
- Medicare Advantage (formerly Medicare+Choice) local and regional managed care plans.

The Centers for Medicare and Medicaid Services has established 34 private prescription drug plan regions and 26 Medicare advantage regions. At least two plans, one of which is to be private, must be available in each region and, if fewer than two plans are available in a region, the Centers for Medicare and Medicaid Services will be responsible for arranging the offering of one regional “fallback” plan.

Financing Medicare Part D

The Office of Management and Budget estimates expenditures related to the Medicare Modernization Act over the next ten years will be approximately \$724.0 billion. Medicare expenditures related to the new drug law for Federal Fiscal Year 2006

are estimated at \$37.4 billion and for Federal Fiscal Year 2007 at \$52.5 billion. Increased expenditures are to be offset by:

- Beneficiary premiums;
- General revenues; and
- State Medicaid “clawback” payments.

The clawback is a monthly state payment to the federal Medicare program, beginning in January 2006. The phased-down state contribution or “clawback,” is anticipated to generate \$48.0 billion in the first five years of the Medicare Part D program, about 13.0 percent of the estimated \$362.0 billion cost of the coverage and low income subsidy over that time period. The monthly payment is determined by the following formula:

Monthly State Payments	=	1/12	x	Per Capita Expenditures (PCE)	x	Dual Eligibles	x	Phase-Down Percentage (PD%)
				State share of per capita Medicaid expenditures on prescription drugs covered under Part D for dual eligibles during 2003, trended forward		Number of dual eligibles enrolled in Medicare Part D plan in the month for which payment is made		Phase-down percentage for the year specified in the statute (e.g. 90 % in 2006)

Impact on Kansas

The October 2005 Consensus Caseload Estimate for the Regular Medical program included adjustments for the implementation of the Medicare Prescription Drug Coverage program beginning January 1, 2006. The adjustments include the cost savings from the shift of pharmaceutical expenditures for dual eligibles - persons eligible for both Medicare and Medicaid -

from the state to the federal government. In addition, adjustments were made for the “clawback” payments to the federal government, anticipated additional enrollment of Medicaid beneficiaries as they are identified during the enrollment process for the prescription drug program, and reduced revenues from drug rebates. The adjustments for FY 2006 and 2007 are shown in the table below:

Adjustments to the October 2005 Consensus Caseload Estimate				
	FY 2006 *		FY 2007	
	SGF	All Funds	SGF	All Funds
Expenditure reduction	(\$39,774,198)	(\$101,985,124)	(\$93,023,964)	(\$238,522,984)
Clawback Payments	25,040,770	25,040,770	64,814,415	64,814,415
Additional Enrollees	601,818	1,543,122	2,655,561	6,809,131
Rebate Reduction	16,777	43,018	17,942,229	46,005,716
TOTAL	(\$14,114,833)	(\$75,358,214)	(\$7,611,759)	(\$120,893,722)

* The FY 2006 estimate reflects only six months of adjustments because the Medicare Prescription Drug program does not begin until January 1, 2006.

COMMITTEE RECOMMENDATIONS

CLIENT RESPONSIBILITY

Health Incentives

In the health care system as a whole, patients are taking a more active role in their own health care through making lifestyle changes, becoming more informed about health care choices, and evaluating the appropriateness of available services in terms of their own needs. The Committee believes this trend should be encouraged by the state's Medicaid program. Some program participants are not wise consumers of health care because they have had limited access to the health care system in the past, lack education about health care and available services, or are not directly responsible for paying for care. The Committee believes changes in behaviors that lead to a healthier life style and appropriate use of the health care system should be encouraged by the state's Medicaid program. Such changes may lead to reduced costs and healthier Kansans.

Recommendation

The Committee recommends the development of demonstration projects to be conducted in one urban area and one rural

area through which Medicaid clients are rewarded for making lifestyle changes that can improve overall health and reduce future health care costs. Examples of such changes are tobacco use cessation and obesity reduction. The Committee envisions that Medicaid clients who achieve established goals of this type could be rewarded with reduced copayments for some Medicaid services, coverage for over-the-counter drugs, or other incentives that are demonstrated to be effective in encouraging life style changes. Demonstration projects are recommended in order to determine the degree to which life style changes actually take place, the most effective incentives, and any unintended consequences. The demonstration projects should be evaluated by an outside contractor annually, and the results should be reported to the Legislature. Various entities, including service providers, public health officials, and program administrators, should be involved in the design of the demonstration projects.

The Committee recommends consideration be given to other demonstration projects that create incentives for Medicaid clients to become more prudent health care consumers. Clients who learn how to use the health care system appropriately through, for example, shopping for prescription medications on the basis of cost in those areas where there

are competing providers, who become familiar with generic drugs, who reduce emergency room and emergency medical service usage could be rewarded through access to additional services, copayment reduction, or other incentives.

The Committee recommends demonstration projects of the type noted herein be initiated as soon as is possible by the Division of Health Policy and Finance and the Kansas Health Policy Authority.

Home and Community Based Services

The Committee reviewed the six home and community based services waiver programs that are operated as a part of the Kansas Medicaid program and determined there is strong support for such programs. The Director of the Division of Health Policy and Finance presented data indicating the growth in both population and expenditures for services provided under the Frail Elderly and Developmentally Disabled waivers, noting the potential “woodworking” effect embodied in such programs, *i.e.*, community-based programs attract persons who would not consider entering a nursing facility which is one of the eligibility criteria for the home and community based waiver programs.

The Committee expresses its strong support for the home and community based services programs.

Recommendation

The Committee recommends the Department on Aging, the Department of Social and Rehabilitation Services, the Department of Health and Environment, the Division of Health Policy and Finance, and the Health Policy Authority coordinate efforts to insure that persons who are being discharged from hospitals or evaluated for nursing facility placement are informed of the array of services available to them in both alternate levels of adult care homes and the community. The agencies should insure that community organizations and agencies they work with develop appropriate

mechanisms to insure that information is available locally.

Independence Plus

In the late 1990s, three states initiated 1115 waiver demonstrations developed in cooperation with the Robert Wood Johnson Foundation and a division of the Department of Health and Human Services that came to be known as Cash and Counseling demonstrations. The states of Arkansas, Florida, and New Jersey developed programs that permitted randomly selected aged and disabled Medicaid clients to handle their own funds and choose the services and service providers the clients believed met their needs. In some cases, when there were small savings realized in the choices made by the clients, participants were permitted to retain these funds in a designated account to purchase health care items not otherwise covered by the state’s Medicaid program. The demonstration projects were evaluated annually by an outside entity during the life of the demonstration waivers. Evaluations indicated a high satisfaction rate, *i.e.*, in the 97th to 98th percentile, on the part of participants. While spending during the first year of operation was higher than traditional Medicaid, by the second post-enrollment year the differential was non-existent. The early research seems to indicate there is a potential for considerable savings when individuals are permitted to handle their health care dollars. In addition, the demonstrations indicated clients had greater access to health care and a greater ability to purchase needed equipment and supplies. In the fall of 2004, 11 additional states received Robert Wood Johnson grants to develop Cash and Counseling demonstration programs. Kansas applied for a grant from the Foundation and, although commended by the Foundation on the excellence and innovativeness of the application, did not receive a grant because the application did not include the elderly, one of the two groups targeted by the Foundation.

The current Administration has endorsed the concepts embodied in the

earlier demonstration projects, and the Centers for Medicare and Medicaid Services has developed a model waiver application form for the states to follow in applying for an 1115 demonstration waiver to operate what are now known as Independence Plus waivers. The intent of the Independence Plus waiver is to use the flexibility of the 1115 authority to increase consumer control over long-term care services, including financial resources, planning, and delivery of services. There are other advantages to an Independence Plus waiver, including the ability to make it applicable to more than one disability population, including those with cognitive disabilities; a state option to provide direct cash resource payments to program participants; and the ability to set the level of care necessary to qualify for home and community based services at a level other than an institutional level of care. Currently, four states have federally approved Independence Plus waivers and a number of others, including Kansas, have applications in some stage of review.

The Committee heard from representatives of the Division of Health Policy and Finance regarding a waiver application to operate an Independence Plus demonstration project to be known as Work Opportunities Reward Kansans (WORK). The proposed waiver targets individuals who are employed, meet all "Working Healthy" eligibility requirements, and require personal services in order to maintain independence and employment. At the time the Committee reviewed the waiver status, the waiver had not yet been approved although the Division had responded to a number of requests for additional information from the Centers for Medicare and Medicaid Services and was anticipating approval of WORK.

Recommendation

The Special Committee on Medicaid Reform recommends the Kansas Health Policy Authority review and evaluate the Cash and Counseling and Independence Plus demonstration projects in place in other states that provide Medicaid clients more

personal responsibility in choosing services and providers and report to the Legislature on a program or programs that could be successfully implemented in Kansas.

COST CONTAINMENT

Family Care Providers and Payroll Agents

In response to a post audit report reviewed by the Committee, the members discussed state policy in regard to payment agents and family care providers and concluded some changes should be made. The Committee concluded family care providers who provide services under a home and community based services waiver program should not be reimbursed at the same rate as contract providers and that changes should be made in the manner in which payment agents for clients who self-direct their care services are selected.

Recommendation

The Committee has introduced legislation that would create new statutes and a statutory state policy in regard to payroll agents and family care providers. The bill provides, after January 1, 2006, that family members of clients who self-direct their services may provide services, but may not be reimbursed at more than 75 percent of the regular reimbursement rate for such services. For the purposes of the bill, family member is broadly defined.

The Committee has requested a bill reflecting the same policy changes be drafted, with the addition of a requirement that the Kansas Health Policy Authority request waiver authority to allow clients to choose services and service providers and self-direct such services under each of the six home and community based waiver programs. The Committee requests the bill, when drafted, be introduced by the Senate Committee on Ways and Means.

Fraud and Abuse

Any program of the magnitude of Medicaid has the potential for significant fraud and abuse by program clients, providers, and contractors. In considering fraud and abuse, the Special Committee reviewed the performance audit, *Medicaid Cost Containment: Controlling Fraud and Abuse*, submitted to the Legislature in January of 2002 by the Legislative Division of Post Audit. In the 2002 report, the auditors noted national statistics indicated approximately 10 percent of all Medicare and Medicaid payments were fraudulent. If the national rate cited by the auditors had been applied to Kansas in 2002, potentially more than \$138 million of the state's Medicaid claims were fraudulent. The 2002 Post Audit study referenced common types of fraudulent or abusive practices that were identified and made recommendations relating to the fiscal agent (then Blue Cross-Blue Shield) and its surveillance and utilization review unit (SUR) staff, the Department of Social and Rehabilitation Services response to practices uncovered by SUR reports and contract oversight, and the underutilization of the Medicaid Fraud and Abuse Unit in the Office of the Attorney General.

The Committee, in its follow-up on the 2002 study, received testimony on fraud, abuse, and payment errors from the new fiscal agent, Electronic Data Systems (EDS); the Medicaid Director; Social and Rehabilitation Services personnel; the Director of the Legislative Division of Post Audit; and the Director of the Medicaid Fraud and Abuse Unit in the Office of the Attorney General. The Committee received information on the capabilities of the Medicaid Management Information System (MMIS) that has been put in place since the 2002 study, the type of data the new system can generate, and the type of SUR activity now in place.

While no specific data relating to the percent of current Kansas claims involving fraud, abuse, and error were given to the Committee, neither was data presented to

indicate Kansas varies significantly from national norms in terms of payment error rates and fraud or abuse. With the growth in the Kansas Medicaid program costs since the 2002 audit report, if a fraud rate of as little as one percent were applied to FY 2006 approved expenditures, a rate substantially less than the national study cited by Post Audit in 2002, fraudulent or erroneous payments would total \$22.0 million. A five percent rate would indicate a potential cost of \$110 million.

The Committee has a strong commitment to control of fraud and abuse by all parties involved in the Medicaid program and offers the following recommendations the members believe will strengthen efforts to combat fraud or abuse.

Consumer Fraud. It was brought to the attention of the Committee that misuse of a legitimate Medicaid card by an ineligible individual and other actions that allow ineligible individuals to access Medicaid services can occur in the Medicaid program. While there are program sanctions that are used in such instances, the Committee concluded additional attention should be given to this type of client abuse of the Medicaid program.

Recommendation. The Committee recommends the appropriate committees review the penalties for consumer fraud applicable to Medicaid clients and determine whether additional penalties should be established.

False Claims. During discussion of fraud and abuse, the Committee received a presentation from a member of the House in regard to a bill draft relating to bringing civil actions and recovering damages for the submission of false or fraudulent claims to an agency of the state or local government. In general, the proposed legislation would authorize the Attorney General or a private plaintiff to bring a civil action for false or fraudulent claims submitted to agencies of the state or local governments of the state. The Committee had several concerns with the inclusion in the proposed bill of

allowing false claims actions to be brought by private entities. The Committee also reviewed a false claims bill introduced in 2002, but not enacted. The latter bill would have authorized the Attorney General to file a civil action for damages and recovery on fraudulent Medicaid claims. The Committee discussed this issue at length and concluded authorization for civil actions arising from false or fraudulent claims against any agency of the state should receive consideration by the 2006 Legislature.

Recommendation. The Special Committee on Medicaid Reform has drafted and introduced a bill that would authorize the Attorney General to bring a civil action for false claims filed with any agency of the state. The Committee bill is similar to the legislation proposed in 2002, but is not applicable exclusively to the Medicaid program.

Forfeiture and Seizure. The Special Committee reviewed the provisions of 2005 HB 2445, a bill requested by the Attorney General, that would amend an existing statute to add Medicaid fraud to the list of crimes for which seizure and forfeiture is allowed. The bill is pending in the House Committee on Appropriations. After review, the Committee concluded HB 2445 would add another valuable tool for preventing and prosecuting fraud in the Medicaid program.

Recommendation. The Committee recommends HB 2445 be rereferred to the House Committee on Corrections and Juvenile Justice and recommends the House committee hold a hearing on the bill. The Special Committee requested that the Chair and Vice-Chair send a letter to the House committee encouraging consideration of the bill and expressing the Committee's support for its passage.

Identity Verification. After review of the present procedures utilized in processing an application for Medicaid eligibility, the Committee concluded the process should be strengthened to preclude abuse by applicants who may not meet eligibility criteria.

Recommendation. The Committee recommends the 2006 Legislature review the need for a more complete identity verification for persons accessing the Medicaid program. The Committee notes the Department of Revenue has developed a source verification process for motor vehicle operator's license applicants and recommends the 2006 Legislature consider the implementation of a similar procedure for the verification of Medicaid applicants.

Office of Inspector General

The Committee considered the overall magnitude of Medicaid and MediKan in terms of expenditures and the number of persons who depend on one or more components of the programs for health services and concluded an Office of Inspector General should be created to provide a locus for investigations of issues that affect the program.

Recommendation. The Committee has drafted and introduced a bill that would create the Office of Inspector General in the Kansas Health Policy Authority. The bill provides for the selection of the Inspector General; sets out the qualifications for such office; and states the Inspector General is to oversee programs administered by the Authority in order to prevent, detect, and eliminate fraud, waste, abuse, mismanagement, inefficiency, and misconduct; is to serve as liaison with law enforcement, investigatory, and prosecutorial agencies; and is to make annual reports to the Legislative Post Auditor, the Legislature, and the Governor. The bill also amends the Kansas Whistleblower Act to add the Inspector General to the definition of auditing agency in the amended statute.

The Committee recommends the bill be enacted by the 2006 Legislature.

Additional Recommendation. The Committee further recommends the appropriate committee in each House consider the false claims bill, the bill creating the office of Inspector General in

the Health Policy Authority, and HB 2445 together as a package. The Special Committee recommends the enactment of all three bills.

MediKan

MediKan is the state-funded program that provides limited health care coverage for adults who do not qualify for Medicaid and who are applying for Social Security Disability Insurance (SSDI) or Supplemental Security Income (SSI)—federal programs that provide cash assistance for persons with disabilities. MediKan, which is administered by the Division of Health Policy and Finance in the Department of Administration, covers eligible adults during the period an application for Social Security Disability Income or Supplemental Security Income is being processed. Eligibility is generally limited to 24 months, although some individuals who meet “hardship” criteria may remain MediKan-eligible for a longer period of time. Persons who qualify for MediKan also receive General Assistance cash assistance through the Department of Social and Rehabilitation Services. Individuals who qualify for one of the two federal assistance programs are then eligible for Medicaid. Once eligibility for one of the federal programs has been approved by the Social Security Administration, the state can claim federal financial participation retroactively for the MediKan expenditures for such individuals

Currently, in order to qualify for MediKan, applicants must have a certification from a physician indicating the applicant has a condition that is expected to last for 12 months or more and cannot be remediated by medication, surgery, or other treatment. Since, at the present time, the application procedure for MediKan is less stringent than the procedure followed by the Social Security Administration in determining disability, more adults qualify for MediKan than actually become eligible for one of the federal disability programs. The Committee was told about 26 percent of MediKan clients actually qualify for Social Security Disability Insurance or

Supplemental Security Income and thereby become Medicaid eligible. In recent years MediKan has grown significantly in both the number of persons covered and total expenditures. In the last fiscal year alone, expenditures increased by 35 percent and the number of persons covered by 14 percent. In fiscal year 2005, the state spent \$29.7 million for MediKan coverage for an average of 4,500 covered persons.

The Division of Health Policy and Finance is proposing a new eligibility determination process for MediKan. Under the new procedure, known as presumptive disability determination, an individual applying for MediKan will be referred for a disability determination that more closely follows the procedures of the Social Security Administration by requiring the submission of medical records and a presumptive disability determination by Disability Determination Services, an entity that is also the Social Security Administration contractor. If the person is found presumptively disabled, the Department of Social and Rehabilitation Services will determine if the individual is financially eligible for Medicaid, and, if so, the individual will begin receiving Medicaid benefits. The Division of Health Policy and Finance views presumptive eligibility determination for Medicaid as a pilot for applying presumptive eligibility procedures to other areas of the Medicaid program.

Recommendation

The Special Committee on Medicaid Reform recommends the Division of Health Policy and Finance move forward in implementing Medicaid presumptive eligibility determination for Social Security Disability Insurance and Supplemental Security Income applicants seeking medical assistance as rapidly as possible. The Committee believes the revised procedure will cut down on the number of persons who do not eventually qualify for Medicaid.

Spend-down Caps

In reviewing the “spend-down” individuals must meet to qualify for Medicaid coverage, the Committee discovered the Division of Health Policy and Finance now follows the Supplemental Security Income standards as the state policy relating to the personal effects and property an applicant is not required to count toward the spend-down of the applicant’s income and assets to qualify. In essence, this means an applicant may have one car regardless of the value thereof, a home in which the applicant resides, certain income producing property, and most personal effects that are not counted toward eligibility. The federal definition uses the term “frivolous” in regard to personal effects, but does not define the term. The Committee members concluded there should be some limitation on the value of an automobile and a residence that is not counted for the purpose of eligibility.

Recommendation

The Committee encourages the Division of Health Policy and Finance to establish caps on the value of an automobile and personal effects that are not counted for the purpose of meeting the spend-down necessary to qualify for Medicaid. In making this recommendation, the Committee notes there is an opportunity for an applicant to receive a hardship waiver if warranted.

Strategies

During the Committee deliberations, the Director of the Division of Human Services in Sedgwick county brought to the Committee’s attention proposed Medicaid cost containment strategies that had been prepared for Committee consideration. Appendix B contains the proposed recommendations. The Committee requested staff to prepare information as to the actions that would be necessary to implement the recommendations. This information is contained in Appendix B.

Recommendation. The Committee recommends the Department of Social and Rehabilitation Services, the Division of Health Policy and Finance, the Kansas Health Policy Authority, the Department on Aging, and the Department of Health and Environment review the proposed cost containment strategies submitted to the Committee and report to the 2006 Legislature. The Committee requested that transmittal letters be sent to the appropriate state agencies requesting the recommended review.

LONG-TERM CARE

Adult Care Homes

Liability Insurance. The Committee reviewed 2005 HB 2294, noting the bill was not acted on by the House Committee on Appropriations because a number of issues were raised by the Insurance Department. The bill, which was introduced at the request of the Kansas Association of Homes and Services for the Aging, would create an act under which adult care home group liability insurance pools could be created and was based on the existing Kansas statutes that authorize group funded insurance pools. The bill was reworked during the interim by the Association and representatives of the Insurance Department, and a completely new version of the bill was presented to the Committee. The proposed new legislation is based on the Workers’ Compensation pool laws and, according to representatives of the Association, meets with the approval of the Insurance Department.

Recommendation. The Special Committee agreed to introduce the replacement for HB 2294 as a Committee bill and to recommend the bill be referred to the House Committee on Insurance.

Reimbursement. The Committee reviewed the method utilized by the Department on Aging in establishing annual reimbursement rates for nursing facilities and concluded the methodology should be

changed. Currently, the base is the cost report for the 2001 fiscal year factored for inflation. The reimbursement methodology is established by rules and regulation rather than by statute. The Committee concluded Medicaid reimbursement needs to be revisited and proposes a change as noted in its recommendation.

Recommendation. The Special Committee on Medicaid Reform recommends the Department on Aging adopt a nursing facility reimbursement policy that re-bases the compensation made to nursing facilities annually and that the new base be computed using a rolling average of cost figures for the prior three years.

Skilled Nursing Facility Assessments. The Committee also reviewed 2005 HB 2538 which would provide for assessments on certain skilled nursing facilities based on the payments collected for all residents, except those related to Medicare Part A; the creation of a fund in the state treasury to which the assessments and any federal matching money resulting from the assessments would be transferred, to be used to increase or supplement the rates paid to the facilities for Medicaid clients and for other adult care services; and insuring that any facility assessed would receive additional Medicaid reimbursement in at least the amount of the assessment paid by the facility. The introduction of the bill was requested by the Kansas Health Care Association. Following review, the Committee had a number of questions about the provisions of the bill, including whether certain of the provisions are allowed under federal law.

Recommendation. The Committee recommends the Health Policy Authority and the Department on Aging consult with the Centers for Medicare and Medicaid Services about the possibility of the state initiating a skilled nursing facility provider tax and determine whether community based services would be subject to any such assessment.

Partnerships for Long Term Care

Four states—California, Connecticut, Indiana, and New York—have been operating partnership programs in which private sector long-term care insurance is partnered with the state's Medicaid program. Although there are differences in the approach taken by the four states, the basic premise on which the "partnership" is based is that individuals who purchase private long-term care insurance and exhaust its coverage should be able to access Medicaid and still protect a portion of their assets. The partnership states follow one of two models—the dollar-for-dollar model and the total asset protection model. In the dollar-for-dollar model, beneficiaries are able to keep assets in an amount equal to the benefits paid by their insurance and still be eligible for Medicaid. In the total asset protection model, all assets are protected for Medicaid purposes once the individual's insurance has covered long-term care for a specific number of years, typically three or four years.

At a time when other states were beginning to examine the partnership concept as one part of a multi-faceted approach to developing more individual responsibility for long-term care, Congress enacted legislation prohibiting expansion of the partnership concept to other states, while allowing the four states with partnership programs in place to continue their programs. There is widespread support for removing the federal prohibition on expansion of the partnership concept, and 17 states have enabling legislation in place should the federal law be changed.

Recommendation

The Special Committee has introduced a bill that creates enabling legislation that would authorize implementation of a partnership program should the federal ban be lifted. The Committee recommends further, that members of the legislative and executive branches work with the Kansas members of Congress and through national organizations to encourage Congress to act to

give the states the flexibility to develop partnership programs.

Protection of Assets

As Medicaid has changed over the years since the enactment of Title XIX of the Social Security Act in 1965, more and more of the costs of the program arise from services and populations that were not envisioned when Medicaid was created. Conceived as a program to make health care available to the very poor, especially women and children, Medicaid has become a program that nationwide pays for half of mental health services, more than half of all HIV/AIDS care, 40 percent of all births, 25 percent of health care for children, 50 percent of long-term care, and two-thirds of all nursing facility residents' care. In Kansas, the average Medicaid expenditure for seniors and persons with disabilities is far greater than the expenditure for low-income children and their caretaker adults.

A large percentage of seniors become eligible for Medicaid through a "spend-down" of their assets and income to the level of eligibility. It is believed an unknown number of such persons take advantage of federal law to protect their assets by transferring them to their spouse or children or other family members.

Under current federal law, states must review the countable assets of an individual applying for Medicaid for a "look back" period of 36 months prior to application or for 60 months if a trust is involved. Applicants are prohibited from making transfers of countable assets during the look-back period for the purpose of becoming Medicaid eligible. If an unlawful transfer is identified, current federal law requires the state to impose a penalty period during which Medicaid will not pay for long-term care. The length of the penalty period is calculated by dividing the amount of assets transferred by the monthly average payment by private pay nursing facility residents in the state. The penalty date currently starts with the date assets are transferred.

There is widespread support nationally for allowing the states more flexibility in dealing with the transfer of assets for the purpose of becoming eligible for Medicaid subsidized long-term care. Specifically, the National Association of State Legislatures, the American Legislative Exchange Council, the National Governor's Association, the Medicaid Commission appointed by the Secretary of Health and Human Services, and the Kansas President's Task Force on Medicaid Reform have all expressed support for:

- Increasing the "look-back" period to determine whether assets have been transferred for the purpose of becoming Medicaid eligible from three to five years, and
- Moving the start date for calculation of the penalty period for transferring assets from the date of the asset transfer to the date of application for Medicaid.

Recommendation

The Special Committee recommends support for the above changes through work with the Kansas Congressional delegation to assure support for federal legislation to bring about needed changes relating to the transfer of assets. The Committee also recommends the 2006 Legislature adopt legislation directing the state Medicaid agency to make changes in Kansas policy in regard to the transfer of assets as soon as federal law permits. The Committee sees a tightening of the controls on the transfer of assets to protect an estate from the cost of long-term care as one part of a much needed effort to convince individuals to take responsibility for their own long-term care.

SYSTEM CHANGES

During its deliberations, the Special Committee on Medicaid Reform studied several issues that relate to procedures followed in the Medicaid program, and the Committee concluded changes could be

made that would improve the efficiency and effectiveness of the program over the short term. One of the Committee recommendations can be accomplished by the Division of Health Policy and Finance without statutory action.

Prescription Drug Prescriber Identification

The Committee spent some time on the manner in which the Medicaid Management Information System handles prescription drug claims and the types of data that can be retrieved from the system. One issue of concern to the Committee is that of being able to identify practitioners whose prescribing practices vary from the norm significantly. Being able to identify such practitioners is critical both to assuring quality care for Medicaid clients and insuring that practitioners are making prudent use of prescription drugs that are effective and meet generally accepted practice standards. At the present time, the prescribing practitioner is not always identified on a pharmacy claim thereby negating some of the benefits that could result from better use of data arising from the claims system.

Recommendation

The Committee recommends the Division of Health Policy and Finance immediately require every pharmacy claim submitted to the fiscal agent for payment to contain the Drug Enforcement Administration (FDA) identification number of the prescriber.

Prescription Drug Pricing

Due to the rapid increases in the prices of prescription drugs under the Medicaid program in recent years, the Committee spent a considerable amount of time on issues that relate to this topic. One area in which the President's Task Force and the Secretary's Medicaid Commission made recommendations is that of the price determinant used by most Medicaid programs to determine pharmacy reimbursement. Currently, the Average Wholesale Price or AWP, which is the published suggested wholesaler price of a drug to retailers compiled in the form of a third-party compendium and which is typically higher than the price actually paid by the purchaser of the drug is used by most Medicaid programs, including Kansas. The Secretary's Medicaid Commission recommends allowing states to establish pharmaceutical costs based on the Average Manufacturer's Price (AMP) rather than the published Average Wholesale Price. The President's Task Force recommended exploring the state securing a purchase price for the individual pharmacy that is as low as the drug can be purchased anywhere in the United States. The Task Force noted the recommendation would require a change in federal law.

Recommendation

The Committee recommends, with the approval of the Legislative Coordinating Council, a letter be sent to the Kansas Congressional delegation urging them to support Medicaid reforms that would give the states more flexibility in determining the rates paid for prescription drugs under the Medicaid program.

Total Medicaid Expenditures

FY 1997 Actual - FY 2011 Estimate

<u>Fiscal Year</u>	<u>SGF</u>	<u>All Funds</u>	Percent Change From Previous Year	
			<u>SGF</u>	<u>All Funds</u>
1997	\$321,725,146	\$877,217,879	n/a	n/a
1998	337,336,819	929,970,745	4.9%	6.0%
1999	389,784,277	1,074,109,526	15.5	15.5
2000	443,869,702	1,225,925,544	13.9	14.1
2001	432,898,173	1,310,490,427	(2.5)	6.9
2002	411,100,658	1,472,222,150	(5.0)	12.3
2003	490,421,695	1,568,105,487	19.3	6.5
2004	551,741,190	1,693,797,337	12.5	8.0
2005	699,589,196	2,075,191,237	26.8	22.5
2006	747,356,102	2,197,035,142	6.8	5.9
2007	811,018,151	2,323,968,305	8.5	5.8
2008	886,733,785	2,540,197,452	9.3	9.3
2009	967,347,825	2,771,424,223	9.1	9.1
2010	1,054,788,130	3,022,394,403	9.0	9.1
2011	1,149,900,001	3,298,410,899	9.0	9.1
Change from FY 1997 to FY 2011 Estimate			257.4%	276.0%



Sedgwick County, Kansas

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Testimony to the Special Committee on Medicaid Reform November 2, 2005

The Division of Human Services, a part of Sedgwick County Government, is comprised of Sedgwick County Developmental Disability Organization, Central Plains Area Agency on Aging, and COMCARE Community Mental Health Center. We appreciate the opportunity to present cost containment recommendations for Medicaid. Our focus is to meet the needs of our most vulnerable populations while being fiscally responsible. The following recommendations are from each of the Departments in the Division followed by some general concepts/initiatives to consider.

Community Developmental Disability Organization (CDDO):

1. Invest Funding on the Front End to Save Dollars Over the Lifespan. Presently there are no supports or therapies offered to children with developmental disabilities through the Medicaid waiver prior to age 5. There may be value in looking at systems utilized by other states to determine if offering DD-specific supports or therapies during the first five years of life may reduce the requirement for services throughout the lifespan.
2. Revise Access to Medicaid Cards. Some families utilize HCBS waiver services for their child simply to maintain a medical card. While finding these families and taking away the medical cards may be one course of action to save funding, a more realistic option may be to find a way to allow them access to the medical card without receiving MR/DD system supports they do not really need.
3. Enhance Flexibility. There may be families who could purchase services more efficiently if they were not constrained with Medicaid requirements. The most efficient funding utilized by the MR/DD system involves state general fund dollars that are not matched through Medicaid. For example, some families utilize unmatched dollars to purchase respite care from individuals they know and trust at rates far lower than are paid through Medicaid. This is a tradeoff in terms of accountability for the quality of service that is provided, but some families do seem to prefer to have flexibility with fewer dollars to better meet the needs of the individual with the disability.

Area Agency on Aging (AAA):

1. Shared Risk in the HCBS-Frail Elderly Waiver Program. This would change the services offered so that the client would not be required to accept all the services identified in the needs assessment, but would instead allow the client to choose which services they would like to receive. In this scenario, the client would have to accept some limited amount of risk in the choice to go without services that were identified as necessary in the assessment process. This process is one that is currently utilized in the Senior Care Act (SCA) program; the client is allowed to choose their services. The average cost per SCA client is around \$100 monthly, and the average cost per HCBS client is \$820 monthly.
2. Case Management Stationed at Hospitals. By stationing AAA case managers at hospitals, they can begin the process of planning for discharge of seniors. This would include assisting and working with caregivers, developing plans with family members, friends, neighbors and churches to maximize informal services, and when necessary, access formal services such as Older American Act services, Senior Care Act and HCBS-FE waiver services. By providing this service at the front end, those discharged to the community are better planned for, informal services are coordinated, formal services are implemented in a timely manner, and the client is less likely to relapse and end up back in the hospital due to lack of self care and reoccurring acute care issues.

Community Mental Health Center (CMHC):

1. Shift Mental Health Coverage to Private Sector. Provide Mental Health Parity or increased incentives to maintain or improve employee benefits for mental health coverage. Parity involves providing coverage for mental illnesses in the same comprehensive manner that we provide for physical illnesses. Research shows that there is a decrease in total health care costs when individuals receive the mental health treatment that they need. Parity can also help to reduce the stigma that is still often associated with seeking mental health services. People with serious mental illness can often only get the services they need by applying for Medicaid.
 2. Use Evidence-Based Methods. Support working with Medicaid to appropriately incentivize the use of evidence-based practices. These are practices that have been proven to be effective with demonstrated outcomes. There are a growing number of treatment interventions that are emerging as best practices or promising approaches to treating mental illness and addiction. Many times when evidence-based medications and psychosocial interventions are used in tandem the result is successful treatment. Medicaid and Medicare must keep current with advances in evidence-based practices and continuously examine these practices within the context of reimbursement policies.
 3. Reduce Premature Admission to Nursing Homes. Increase focus on mental health outreach to older adults, which would lead to reducing the premature admissions to nursing facilities for those who are depressed and/or dealing with other mental health
-

related challenges. Our complex mental health system can overwhelm consumers. Older adults have not often sought treatment on their own. Evidence has shown that offering a full range of community-based alternatives is more effective than hospitalization and emergency room treatment when mental health concerns arise.

Other Concepts or Initiatives:

1. S-CHIP Pilot Project. Some localities have sought waivers to expand the federally funded S-CHIP (the HealthWave Program in Kansas) to increase access to those other than children. One approach could be based on the Three-Share program in Muskegon, Michigan. A non-profit organization (the Muskegon Community Health Project) manages a Three-Share Insurance Coverage Model that provides an insurance product to employees of small businesses in the community that meet certain financial criteria. To simplify eligibility determinations, the program certifies businesses rather than individuals. The cost of the insurance is shared 30% by the employee, 30% by the employer and 40% by the community with the community funds coming primarily from hospital disproportionate share funding. The product available for those eligible is a comprehensive health insurance plan emphasizing prevention. The Three-Share Model is now being replicated based on the Muskegon model in a number of communities.

One approach to Medicaid cost containment would be to initiate a small pilot of a Three-Share model in an urban community in Kansas. It may be possible to use S-CHIP funds as the 40% community share. By covering children (and their families) at the cost of 40% of an insurance product rather than 100% of the S-CHIP coverage, this could result in better utilization of health care resources and cost savings.

2. Chronic Disease Management. The care management program that is starting in Sedgwick County will be an important pilot to monitor. This is a contract between the state of Kansas and the Central Plains Regional Healthcare Foundation. This could be a positive approach that could improve health and result in cost savings. There have been similar approaches to this in other states. It focuses on working with people who are on Medicaid and have a chronic disease, such as diabetes or asthma. The focus is helping patients manage their disease and avoid costly hospitalization or complications.
3. Dental Care to Prevent Bigger Health Problems. Providing dental care for adults on Medicaid should be considered. Studies continue to demonstrate the connection between dental care and the general health of the individual. Proper dental care can prevent premature births, heart disease, pneumonia, and other health concerns. Dental problems can interfere with a person's ability to seek and maintain employment. It can increase the cost of caring for the most disabled.

Thank you for allowing us this opportunity.

Proposed Medicaid Cost Containment Strategies						
	Type of Change Necessary to Implement					
	Statutory	Change to State Rules and Regs	Federal Approval Required	Additional Funding	Program already exists in some form	
Community Developmental Disability Organizations (CDDOs)						
Invest Funding on the Front End to Save Dollars Over the Lifespan	?	X	X	X	X	1
Revise Access to Medicaid Cards		X	X	X		
Enhance Flexibility		X	X	X		
Area Agencies on Aging (AAAs)						
Shared Risk in the HCBS/Frail Elderly Waiver program		X	X			
Case Management Stationed at Hospitals					X	2
Community Mental Health Centers (CMHCs)						
Shift Mental Health Coverage to Private Sector	X				X	3
Use Evidence-Based Methods					X	4
Reduce Premature Admission to Nursing Homes				X		
Other						
S-CHIP Pilot Project	X	X	X	X		
Chronic Disease Management		X	X	X	X	5
Dental Care to Prevent Bigger Health Problems		X	X	X		

1. Kansas Department of Health and Environment Infants and Toddlers Program and the Education System

2. This is currently being done as a pilot project.

3. Partially covered in current insurance law.

4. Already being used.

5. The Medicaid managed care organization (FirstGuard) already uses disease management.